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## **Kansas Legislature**

**February 1, 2007**

### **Report on the Massachusetts Commonwealth Health Insurance Connector Program**

The 2006 Kansas Legislature, as outlined in proviso, directed the Kansas Health Policy Authority (KHPA) to prepare a report about the Massachusetts Commonwealth Health Insurance Connector Program. The proviso specified that the KHPA “study the Massachusetts commonwealth health insurance connector program and provide a report....on the feasibility of implementing a similar plan in Kansas.”

#### **Executive Summary**

In 2006 Massachusetts enacted a law that would provide nearly universal health coverage to state residents. Key elements of that law include:

- An individual mandate requiring all state residents to purchase health insurance
- A requirement that employers offer health insurance or pay an assessment
- Creation of the Commonwealth Health Insurance Connector that links funding sources and health plans in a simplified market
- Provision of government-funded subsidies to low-income individuals to assist with the purchase of health insurance

In October, 2006 Massachusetts began the first phase of implementation, enrolling non-Medicaid eligible adults with household incomes at or below the federal poverty level (FPL) in the Commonwealth Care Health Insurance Program. This program is administered by the newly created Commonwealth Health Insurance Connector Authority. The Connector is an independent public authority established to facilitate the purchase of health insurance for individuals and small businesses (50 or employees). The Connector is governed by a ten member board. Funding for the Connector comes from the state, Federal Medicaid matching funds, employer contributions, and individual premiums.

The Connector is a private insurance purchasing pool designed to connect individuals and small employers with affordable, quality insurance products. Two sets of health insurance plans are to be offered through the Connector: Commonwealth Care plans and Commonwealth Choice plans. Commonwealth Care is a heavily-subsidized set of health insurance plans designed primarily for individuals below 300 percent FPL.

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Commonwealth Choice is an array of health plans sold through the Connector for individuals with incomes greater than 300 percent of FPL. Commonwealth Choice health plans is not subsidized.

In assessing the feasibility of replicating the Massachusetts Connector in Kansas it is important to examine the climate and extenuating circumstances which existed when this policy initiative was adopted in Massachusetts. The state has a high level of employer sponsored health insurance and over the last decade has undertaken Medicaid expansions so Massachusetts has a relatively low rate of uninsured individuals. In addition they had great incentive to undertake health care reform because \$385 million in federal funds were at risk when their Medicaid waiver expired in July, 2006.

Kansas too has a relatively low rate of uninsurance, moderately high level of employer sponsored health insurance, and similar level of Medicaid coverage for children. The majority of the uninsured in our state are low-wage full-time workers employed in small businesses. Small employers struggle to find affordable health insurance for their employees and there are very limited options for those in the non-group market. An entity such as the Connector which serves as a clearinghouse to facilitate the pooling and purchasing of health insurance could facilitate access to health insurance products by small employers and individuals. Certain elements of the Massachusetts Connector model, however appear to be fundamental to that goal; subsidies for low income workers, a mechanism to pool payments from multiple payers, variation in plans, use of pre-tax dollars for health insurance purchase, plan quality verification, and establishment of an adequately financed infrastructure.

## **Background**

On April 12, 2006 the Governor of Massachusetts signed into law legislation (H. 4650) that would provide nearly universal health care coverage to residents of the state. Key elements of that law include:

- An individual mandate requiring all state residents to purchase health insurance
- A requirement that employers offer health insurance or pay an assessment
- Creation of the Commonwealth Health Insurance Connector that links funding sources and health plans in a simplified market
- Provision of government-funded subsidies to low-income individuals to assist with the purchase of health insurance

On October 2, 2006, Massachusetts began the first phase of implementation, enrolling non-Medicaid eligible adults with household incomes at or below the federal poverty level (FPL) in the Commonwealth Care Health Insurance Program. This program is administered by the newly created Commonwealth Health Insurance Connector Authority. By the end of 2006, over 28,000 adult had enrolled in one of the Commonwealth Care health plans.

## **Commonwealth Health Insurance Connector**

**Definition.** The Connector is an independent public authority established to facilitate the purchase of health insurance for individuals and small businesses (50 or employees). The Connector is governed by a ten member board. Six directors come from the private sector: three appointed by the Governor (an actuary, a health economist, and a small business representative) and three by the Attorney General (an employee health benefits plan specialist, a health consumer representative, and a representative of organized labor) and four directors representing state agencies (Secretary of Administration and Finance, Secretary of Health and Human Services, Commissioner of Insurance, and the Medicaid Director). The stated mission of the Connector is “promoting health care coverage across the Commonwealth”.

**Agency Functions.** The Connector is a private insurance purchasing pool designed to connect individuals and small employers with affordable, quality insurance products. Larger businesses with more than fifty employees are not eligible to participate in the Connector, but may use the Connector to arrange for coverage for their employees who are not eligible for benefits. Plans that are purchased through the Connector are selected by individuals, rather than groups, and are portable, which means that individuals can maintain their insurance coverage regardless of where they work. There are numerous functions assigned to the agency, including: developing benefit guidelines for Commonwealth Care Health Insurance products; certifying the insurance products are “high value and good quality”; contracting with private insurers to provide health plans; collecting premium payments from multiple sources; determining the sliding scale subsidy guidelines for individuals with incomes less than 300 percent of FPL; transmitting premium payments to insurers; and enrolling the individual in the health plan of their choice or auto-enrolling those who don’t select a plan.

The Connector allows multiple employers to contribute to an employee’s premium purchase. For the 19-26 year old age population who as a group have high rates of uninsurance, the Connector is responsible for offering health insurance plans that are specifically designed to be affordable.. The Connector is also charged with defining premium affordability standards and establishing an appeals process that allows individuals to be exempted from the law if they demonstrate they can’t afford insurance.

**Funding.** Funding for the Connector comes from the state, Federal Medicaid matching funds, employer contributions, and individual premiums. Small businesses enrolling through the Connector are not required to make premium contributions but must adopt at a minimum a Section 125 “cafeteria plan” which permits workers to purchase health care with pre-tax dollars. Companies with 11 or more employees that do not contribute to their employees health insurance premiums will be assessed a “fair share” surcharge and may be assessed a free rider surcharge if their employees access free care. The free rider surcharge assessment is triggered if the employees access free care paid from the uncompensated care pool a total of five times per year or one employee accesses free care more than three times. The surcharge will exempt the first \$50,000 of free care used by employees but after that the employer will be charged between 10-100 percent of the cost to the state, the exact assessment rate to be determined by the Division of Health Care Finance and Policy.

**Health Plans.** Two sets of health insurance plans are to be offered through the Connector: Commonwealth Care plans and Commonwealth Choice plans. Commonwealth Care is a heavily-subsidized set of health insurance plans designed primarily for individuals below 300 percent FPL. Premiums and cost-sharing increase with income. Commonwealth Care has been implemented in two phases: the first phase was implemented in October 2006 and covers about 28,000 poverty-level adults; the second phase is being implemented this month and will cover individuals up to three times the federal poverty level (FPL). Commonwealth Choice is to be implemented in July of this year and is designed for participating groups as well as individuals with incomes above 300 percent FPL. A wider selection of health plans is planned for this arm of the Connector, including high-deductible plans for young adults. Each set of health plans is described in more detail below.

### **Commonwealth Care Health Insurance Plan**

**Definition.** Commonwealth Care is a subsidized insurance program for individuals and employees of small firms who have incomes at or below 300 percent FPL. An individual is eligible to participate if they have been a resident of the state for six months, are Medicaid eligible, and the individual’s employer has not provided health insurance in the last six months. Children of parents eligible for Commonwealth Care are covered through the Medicaid program.

**Phase I.** Commonwealth Care is being phased in over time for low income individuals. For uninsured individuals with incomes at or below the FPL (\$9,800), Commonwealth Care is currently available and no monthly premiums are charged. Benefits include: inpatient hospital services; outpatient and preventive services;

inpatient and outpatient mental health and substance abuse services; dental and vision care; and prescription drugs. The Connector has contracted with four nonprofit health insurance providers to offer Commonwealth Care. The four managed care organizations providing this insurance are; Boston Medical Center Health Net, Fallon Community Health Plan, Network Health, and Neighborhood Health Plan. The premiums paid by the state on behalf of low income individuals for this insurance coverage range from \$280 to \$387 per member per month. The four providers cover the entire state and most enrollees have the choice of two to three plans in their coverage area.

**Phase II.** In early 2007, phase two of the implementation process will ensue, making Commonwealth Care available to persons with incomes of 100.1 percent to 300 percent of the FPL with premiums set on a sliding scale. Proposed premiums will range from \$18 (1.7%) per member per month, for individuals with incomes 100%-150% FPL to \$106 (4.7%), for individuals with incomes 250%-300% FPL. For persons with incomes between 200%-300% FPL there are two cost sharing plans, one with higher premiums and lower co-payments and one with lower premiums and higher co-payments. The benefit package also includes co-payments for most services and out-of-pockets maximums will range from \$500 to \$750 depending upon the plan selected and the income category of the enrollee.

### **Commonwealth Choice Health Plan**

It is anticipated that the third phase of the Connector, Commonwealth Choice, will be implemented July 1, 2007. Commonwealth Choice is an array of health plans sold through the Connector for individuals with incomes greater than 300 percent of FPL. Commonwealth Choice health plans is not subsidized. Individuals participating on their own or through their employer will have an annual choice of three different levels of benefits and premiums. In addition, individuals aged 19 to 26 who do not qualify for group health benefits will be able to purchase lower cost “Young Adult Plans” through the Connector.

### **Feasibility of Replicating in Kansas**

In assessing the feasibility of replicating the Massachusetts Connector in Kansas it is important to examine the climate and extenuating circumstances which existed when this policy initiative was adopted in Massachusetts.

**Massachusetts History.** In 1995, Massachusetts received approval of a Section 1115 waiver from the U.S. Department of Health and Human Services. This waiver allowed Massachusetts to expand Medicaid (MassHealth) and receive federal match funds for supplemental payments made to safety-net managed care organizations. Under the waiver, non-elderly adults below 100-133 percent of the FPL and children below 200 percent of FPL were eligible for Medicaid. Since the demonstration began, the number of Massachusetts residents eligible for MassHealth increased by over 300,000 persons. Fifteen percent of the non-elderly population receive health care services through Medicaid in Massachusetts.

**Massachusetts Demographics.** Massachusetts is among the top tier of states with high rates of employer sponsored health insurance, with 60 percent of residents having employer-sponsored health insurance. The high level of employer sponsored health insurance coupled with Medicaid expansions have resulted in a relatively low rate of uninsured individuals. In 2004, 11 percent of the population in Massachusetts was insured.

A powerful impetus for enactment of the Massachusetts health reform plan (H. 4065) was the pending renewal of that Medicaid Section 1115 waiver. The Centers for Medicare and Medicaid Services (CMS) were scrutinizing the safety net institutional payments in Massachusetts, stipulating that funds be shifted from safety net institutions and into health insurance coverage. Accordingly, \$385 million in federal funds were at risk when their Medicaid waiver was set to expire in July, 2006.

**Massachusetts “Assets” that Contributed to Reform.** Three additional factors were instrumental in the passage of the Massachusetts health reform statute. First, the state had a long history and tradition of tightly regulating the health insurance small group and non-group market. Insurers were required to offer individual insurance if they offered small group insurance and they were required to do so on a modified community rating basis that did not permit health underwriting. Secondly, the state had a reinsurance pool for both the small group and the individual market. Third, since 1985, the state of Massachusetts has had a large (\$600+ million) program to make supplemental payments to hospitals, health care centers, and certain insurers for uncompensated care and Medicaid underpayments. This program was financed by provider and insurer assessments and state and federal tax revenues. Federal matching funds for these supplemental payments were most recently approved through a health care reform waiver granted in 1997, but the Federal government challenged the state’s financing of that waiver, placing \$385 million in federal funds at risk without significant restructuring. Under the newly approved waiver, previously-questioned sources of Federal funds are redirected towards subsidies offered through the Connector. In addition to these redirected supplemental payments, funding for the Massachusetts reform plan will drawn from new funding from employer contributions, \$308 million in new state general funds, and premiums. The first three years of the Massachusetts health plan is estimated to cost \$1.2 billion.

**Kansas Demographics.** Based on some demographic measures, Massachusetts is similar to Kansas. Kansas has a relatively low rate of uninsured individuals (11 percent) and a relatively high level of employer-sponsored health insurance (59 percent). Public health insurance is available to children in households with incomes up to 200 percent FPL,

In terms of health insurance regulation, Kansas has enacted small group health insurance legislation which establishes a mean premium which allows for a 25% variation above and below the mean health insurance rate. This imitates a community rating model for the small group health insurance market, but there has been limited regulatory activity in the non-group market.

**Kansas Business Health Partnership.** In 2000, the Business Health Partnership (BHP) was established with the goal of expanding coverage through a linkage between the public and private sector by improving the affordability and quality of health insurance for low wage workers in small businesses. It was the intended purpose of the legislation creating the BHP that there be available subsidies and/or tax credits to assist low-wage workers in purchasing health insurance. The Business Health Policy Committee membership is statutorily defined by K.S.A. 40-4702. Members include:

- 1) the secretary of the department of commerce and housing or the secretary’s designee;
- 2) the secretary of the department of social and rehabilitation services or the secretary’s designee;
- 3) the commissioner of insurance or the commissioner’s designee;
- 4) one member appointed by the president of the senate;
- 5) one member appointed by the speaker of the house of representatives;
- 6) one member appointed by the minority leader of the senate;
- 7) one member appointed by the minority leader of the house of representatives; and
- 8) three members at large from the private sector appointed by the governor.

**Challenges for Reform in Kansas.** Unlike Massachusetts, Kansas has very limited coverage of adults in Medicaid: eligibility is limited to participants in the Temporary Assistance to Families (TAF) program, who have incomes of no more than 29-36 percent FPL. Kansas also has a much more modest program of supplemental payments to providers, and far fewer federal dollars are dedicated to that purpose.

## **Conclusion**

Kansas' relatively low rate of uninsurance, moderately high level of employer sponsored health insurance, and level of Medicaid coverage for children provide a supportive climate for further policy initiatives to reduce the number of uninsured Kansans. The majority of the uninsured in our state are low-wage full-time workers employed in small businesses. Small employers struggle to find affordable health insurance for their employees and there are very limited options for those in the non-group market. An entity such as the Connector which serves as a clearinghouse to facilitate the pooling and purchasing of health insurance would facilitate access to health insurance products by small employers and individuals. The Business Health Policy Committee currently exists and could assume a similar role as the Connector.

Elements of the Massachusetts Commonwealth Health Insurance Connector program which appear to be crucial in improving access to health insurance for individuals and small employers include; subsidies for low income workers, a mechanism to pool payments from multiple payers, variation in plans, use of pre-tax dollars for health insurance purchase, plan quality verification, and establishment of an adequately financed infrastructure to perform the essential clearinghouse functions which are so burdensome for individuals and small employers. The inclusion of these elements could make health insurance more affordable and attainable for the majority of uninsured Kansans.